Health Advisory:

Hurricane-Displaced Persons Presenting to Local Public Health Agencies With Health-Related Concerns

September 5, 2005

This document will be updated as new information becomes available. The current version can always be viewed at http://www.dhss.mo.gov

The Missouri Department of Health & Senior Services (DHSS) is now using 4 types of documents to provide important information to medical and public health professionals, and to other interested persons:

Health Alerts convey information of the highest level of importance which warrants immediate action or attention from Missouri health providers, emergency responders, public health agencies, and/or the public.

Health Advisories provide important information for a specific incident or situation, including that impacting neighboring states; may not require immediate action.

Health Guidances contain comprehensive information pertaining to a particular disease or condition, and include recommendations, guidelines, etc. endorsed by DHSS.

Health Updates provide new or updated information on an incident or situation; can also provide information to update a previously sent Health Alert, Health Advisory, or Health Guidance; unlikely to require immediate action.

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Health Advisory
September 5, 2005

FROM: **JULIA M. ECKSTEIN**
DIRECTOR

SUBJECT: **Hurricane-Displaced Persons Presenting to Local Public Health Agencies With Health-Related Concerns**

In the aftermath of Hurricane Katrina, multiple thousands of persons have become displaced from their homes, and sizeable numbers of these individuals will be coming to Missouri. One of the concerns following a disaster of this magnitude is the development of disease. To date, the conditions being seen most commonly in persons displaced by the hurricane are: 1) skin rashes, 2) diarrhea, 3) depression, 4) anxiety, and 5) wounds. Note that because cholera and typhoid are not commonly found in the U.S. Gulf States area, it is very unlikely that they would occur after Hurricane Katrina.

All local public health agencies (LPHAs) should be prepared for displaced persons presenting to, or contacting, them with signs/symptoms of illness or other health-related concerns. In preparation for this, each LPHA should do the following:

1) immediately make arrangements with local medical providers (hospital emergency departments and/or private medical providers) for potential referral of displaced persons who present with illness that requires medical evaluation/treatment.
2) immediately make arrangements with local mental health providers for potential referral of displaced persons who present with signs/symptoms that require mental health evaluation/treatment.

If a displaced individual or family presents to, or contacts, the LPHA with health-related concerns, LPHA staff should assess the situation and determine whether further medical or mental health evaluation is indicated, and then refer/advise the individual/family as appropriate. In addition, a normal public health assessment should be conducted. Staff may wish to use the form provided in Appendix A as part of this assessment.

Appendix B contains a document from the Centers for Disease Control and Prevention (CDC) entitled “Guidelines for the Management of Acute Diarrhea.” In addition to treatment recommendations, there are also guidelines regarding when a person with diarrhea should receive further medical evaluation.

Interim immunization recommendations for persons displaced by the hurricane have recently been issued by CDC, and are provided in Appendix C. Questions on providing vaccines to these individuals should be directed to the Missouri Department of Health and Senior Services (DHSS) Immunization Program at 800/392-0272.

Information related to Medicare and Medicaid beneficiaries is available in Appendix D.

More information is available from the following websites:

Hurricane Recovery Efforts (DHSS) http://www.dhss.mo.gov/BT_Response/Recovery.html

Hurricanes: Health & Safety (CDC) http://www.bt.cdc.gov/disasters/hurricanes/index.asp

Coping with Disaster (Missouri Department of Mental Health)
http://www.dmh.missouri.gov/diroffice/disaster/DirectorsOfficeDisasterCopingFactSheets.htm

If you have questions, please contact the DHSS Department Situation Room (DSR) at 800/392-0272.

Initial Health Assessment Form

ID Number _____

Name _____ _____ _____
Last Name First Name M.I.

Age _____yrs/mos (circle one) Race _____ Sex _____

Current medical conditions _____

_____

_____

Prescribed medications _____

_____

Does person have a current supply of their prescribed medications? ____Yes ____ No

If yes, how long will the current supply last? _____

Drug allergies ____Yes ____ No If yes, list: _____

If female: pregnant? ____Yes ____ No

Current signs/symptoms:

Cuts	____Yes	____ No	Vomiting	____Yes	____ No
Skin sores	____Yes	____ No	Diarrhea	____Yes	____ No
Skin rashes	____Yes	____ No	Yellow skin/eyes	____Yes	____ No
Fever	____Yes	____ No	Vaginal or urethral discharge	____Yes	____ No
Pink eye	____Yes	____ No	Other signs/symptoms	____Yes	____ No
Sore throat	____Yes	____ No	If yes, explain:		
Cough	____Yes	____ No			
Shortness of breath	____Yes	____ No			
Chest pain	____Yes	____ No			

Any additional items noticed by person doing assessment:

_____

_____

_____

_____

_____

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____

Title: _____

Date: _____

FOR HEALTHCARE PROVIDERS: GUIDELINES FOR THE MANAGEMENT OF ACUTE DIARRHEA

Increased incidence of acute diarrhea may occur in post-disaster situations where access to electricity, clean water, and sanitary facilities are limited. In addition, usual hygiene practices may be disrupted and healthcare seeking behaviors may be altered. The following are general guidelines for healthcare providers for the evaluation and treatment of patients presenting with acute diarrhea in these situations. However, specific patient treatment should be determined based on the healthcare provider's clinical judgment. Any questions should be directed to the local health department.

CHILDREN

Indications for medical evaluation of infants and toddlers with acute diarrhea

- Young age (e.g., aged <6 months or weight <18 lbs.)
- Premature birth, history of chronic medical conditions or concurrent illness
- Fever ≥38 °C (100.4 °F) for infants aged <3 months or ≥39 °C (102.2 °F) for children aged 3—36 months
- Visible blood in stool
- High output diarrhea, including frequent and substantial volumes of stool
- Persistent vomiting
- Caregiver's report of signs consistent with dehydration (e.g., sunken eyes or decreased tears, dry mucous membranes, or decreased urine output)
- Change in mental status (e.g., irritability, apathy, or lethargy)
- Suboptimal response to oral rehydration therapy already administered or inability of the caregiver to administer oral rehydration therapy

Principles of appropriate treatment for INFANTS AND TODDLERS with diarrhea and dehydration

- Oral rehydration solutions (ORS) such as Pedialyte ® or Gastrolyte ® or similar commercially available solutions containing sodium, potassium and glucose should be used for rehydration whenever patient can drink the required volumes; otherwise appropriate intravenous fluids may be used.
- Oral rehydration should be taken by patient in small, frequent volumes (spoonfuls or small sips); see attached table for recommended volumes and time period.
- For rapid realimentation, an age-appropriate, unrestricted diet is recommended as soon as dehydration is corrected
- For breastfed infants, nursing should be continued
- Additional ORS or other rehydration solutions should be administered for ongoing losses through diarrhea
- No unnecessary laboratory tests or medications should be administered

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- The decision to treat with antimicrobial therapy should be made on a patient-by-patient basis, on clinical grounds, which may include
    - Fever
    - Bloody or mucoid stool
    - Suspicion of seps

OLDER CHILDREN AND ADULTS

Indications for medical evaluation of children > 3 years old and adults with acute diarrhea

- Elderly age
- History of chronic medical conditions or concurrent illness
- Fever ≥39 °C (102.2 °F)
- Visible blood in stool
- High output of diarrhea, including frequent and substantial volumes of stool
- Persistent vomiting
- Signs consistent with dehydration (e.g., sunken eyes or decreased tears, dry mucous membranes, orthostatic hypotension or decreased urine output)
- Change in mental status (e.g., irritability, apathy, or lethargy)
- Suboptimal response to oral rehydration therapy already administered or inability to administer oral rehydration therapy

Principles of appropriate treatment for ADULTS with diarrhea and dehydration

- Oral rehydration solutions (ORS) such as Pedialyte ® or Gastrolyte ® or similar commercially available solutions containing sodium, potassium and glucose should be used for rehydration whenever patient can drink the required volumes; otherwise appropriate intravenous fluids may be used.
- Oral rehydration should be taken by patient in small, frequent volumes (spoonfuls or small sips); see attached table for recommended volume and time period.
- For rapid realimentation, unrestricted diet is recommended as soon as dehydration is corrected
- Additional ORS or other rehydration solutions should be administered for ongoing losses through diarrhea
- No unnecessary laboratory tests or medications should be administered
- Antimotility agents such as Lomotil ® or Immodium ® should be considered only in patients who are NOT febrile or having bloody/mucoid diarrhea. Antimotility agents may reduce diarrheal output and cramps, but do not accelerate cure.
- The decision to treat with antimicrobial therapy should be made on a patient-by-patient basis, on clinical grounds, which may include
    - Fever
    - Bloody or mucoid stool
    - Suspicion of sepsis

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Treatment based on degree of dehydration

Degree of dehydration	Rehydration therapy	Replacement of ongoing losses	Nutrition
Minimal or none	Not applicable	<10 kg body wt.: 60-120 mL oral rehydration solution (ORS) for each diarrheal stool or vomiting episode >10 kg body weight: 120-240 mL ORS for each diarrheal stool or vomiting episode	Continue breast feeding or resume age-appropriate normal diet after initial rehydration, including adequate caloric intake for maintenance
Mild to moderate	ORS, 50-100 mL/kg body weight over 3-4 hours	Same	Same
Severe	Ringers lactate Lactated Ringers solution or normal saline * in 20 mL/kg body weight intravenous amounts until perfusion and mental status improve: then administer 100 mL/kg body weight ORS over 4 hours or 5% dextrose ½ normal saline intravenously at twice maintenance fluid rates	Same: if unable to drink, administer through nasogastric tube or administer 5% dextrose ¼ normal saline with 20 mEq/L potassium chloride intravenously	Same

* In severe dehydrating diarrhea, normal saline is less effective for treatment because it contains no bicarbonate or potassium. Use normal saline only if Ringers lactate solution is not available, and supplement with ORS as soon as the patient can drink. Plain glucose in water is ineffective and should not be used.

NOTE: Restrictive diets should be avoided during acute diarrheal episodes. Breastfed infants should continue to nurse ad libitum even during acute rehydration. Infant too weak to eat can be given breastmilk or formula through nasogastric tube. Lactose-containing formulas are usually well-tolerated. If lactose malabsorption appears clinically substantial, lactose-free formulas can be used. Complex carbohydrates, fresh fruits, lean meats, yogurt, and vegetables are all recommended. Carbonated drinks or commercial juices with a high concentration of simple carbohydrates should be avoided.

DISASTER SAFETY

Interim Immunization Recommendations for Individuals Displaced by Hurricane Katrina

The purpose of these recommendations is two-fold:

- **To ensure that children, adolescents, and adults are protected against vaccine-preventable diseases in accordance with current recommendations.** Immunization records are unlikely to be available for a large number of displaced children and adults. It is important that immunizations are kept current if possible.
- **To reduce the likelihood of outbreaks of vaccine-preventable diseases in large crowded group settings**. Although the possibility of an outbreak is low in a vaccinated U.S. population, it is possible that outbreaks of varicella, rubella, mumps, or measles could occur. Although measles and rubella are no longer endemic to the United States , introductions do occur, and crowded conditions would facilitate their spread. Hepatitis A incidence is low in the affected areas, but post-exposure prophylaxis in these settings would be logistically difficult and so vaccination is recommended. In addition, the influenza season will begin soon and influenza can spread easily under crowded conditions.

I. Recommended Immunizations

If immunization records are available:

Children and adults should be vaccinated according to the recommended child, adolescent, and adult immunization schedules.

See:

- Childhood and Adolescent Immunization Schedule. (www.cdc.gov/nip/recs/child-schedule.htm).
- Adult Immunization Schedule (www.cdc.gov/nip/recs/adult-schedule.htm) .

If immunization records are not available:

Children aged <6 years of age should be forward vaccinated. They should be treated as if they were up-to-date with recommended immunizations and given any doses that are recommended for their current age. This includes the following vaccines:

- Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP)
- Inactivated Poliovirus vaccine (IPV)
- *Haemophilus influenzae* type b vaccine (Hib)
- Hepatitis B vaccine (HepB)
- Pneumococcal conjugate vaccine (PCV)
- Measles-mumps-rubella vaccine (MMR)
- Varicella vaccine if no history of chickenpox
- Influenza vaccine if in Tier 1.* This includes all children from 6-23 month and children up to age 10 with a high risk condition (MMWR 2005;54:749-750). See: www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm
- Hepatitis A is not routinely recommended in all states; state immunization practice should be followed.

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Children and adolescents (aged 11-18 years) should receive the following recommended immunizations:

- Adult formulation tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap)
- Meningococcal conjugate vaccine (MCV (ages 11-12 and 15 years only)
- Influenza vaccine if in Tier 1* (MMWR 2005;54:749-750). See: www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm

Adults (aged >18 years) should receive the following recommended immunizations:

- Adult formulation tetanus and diphtheria toxoids (Td) if >10 years since receipt of any tetanus toxoid-containing vaccine
- Pneumococcal polysaccharide vaccine (PPV) for adults =65 years or with a high risk condition (MMWR 1997;46(No. RR-8):12-13)
- Influenza vaccine if in Tier 1* (MMWR 2005;54:749-750). See: www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm

II. Crowded Group Settings

In addition to the vaccines given routinely as part of the child and adolescent schedules, the following vaccines should be given to displaced person living in crowded group settings:

- **Influenza.** Everyone ≥ 6 months of age should receive influenza vaccine. Children 8 years old or younger should receive 2 doses, at least one month apart.
- **Varicella.** Everyone >12 months of age and born in the United States after 1965 should receive one done of this vaccine unless they have a history of chickenpox.
- **MMR.** Everyone >12 months of age and born after 1957 should receive one dose of this vaccine.
- **Hepatitis A.** Everyone ≥ 2 years of age should receive one dose of hepatitis A vaccine unless they have a clear history of hepatitis A.

Immunocompromised individuals, such as HIV-infected persons, pregnant women, and those on systemic steroids, should not receive the live viral vaccines, varicella and MMR. Screening should be performed by self-report.

Documentation

It is critical that all vaccines administered be properly documented. Immunization records should be provided in accordance with the practice of the state in which the vaccine is administered. Immunization cards should be provided to individuals at the time of vaccination.

Standard immunization practices should be followed for delivery of all vaccines, including provision of Vaccine Information Statements (see http://www.cdc.gov/nip/publications/VIS/default.htm).

Diarrheal diseases

Vaccination against typhoid and cholera are not recommended. Both diseases are extremely rare in the Gulf States, and there is no vaccine against cholera licensed for use in the United States.

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Rabies

Rabies vaccine should only be used for post-exposure prophylaxis (e.g., after an animal bite or bat exposure) according to CDC guidelines.

***Influenza Tier 1** (MMWR 2005;54:749-750). See: www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm

Tier 1 recommendations include the following priority groups:

- Persons ages ≥ 65 years with comorbid conditions
- Residents of long-term care facilities
- Persons aged 2-64 years with comorbid conditions
- Persons ≥ 65 years without comorbid conditions
- Children aged 6-23 months
- Pregnant women
- Healthcare personnel who provide direct patient care
- Household contacts and out-of-home caregivers of children aged <6 months

For more information, visit www.bt.cdc.gov/disasters,
or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

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Public Affairs Office

FACT SHEET

FOR IMMEDIATE RELEASE
September 2, 2005

Contact: CMS Public Affairs
(202) 690-6145

CMS ACTIONS TO HELP BENEFICIAIRIES, PROVIDERS IN KATRINA STRICKEN AREAS

The Centers for Medicare & Medicaid Services has acted to assure that the Medicare, Medicaid and State Children's Health Insurance Programs will flex to accommodate the emergency health care needs of beneficiaries and medical providers in the Hurricane Katrina devastated states.

Many of the programs' normal operating procedures will be relaxed to speed provision of health care services to the elderly, children and persons with disabilities who depend upon them.

Because of hurricane damage to local health care facilities, many beneficiaries have been evacuated to neighboring states where receiving hospitals and nursing homes have no health care records, information on current health status or even verification of the person's status as a Medicare or Medicaid beneficiary. CMS is assuring those facilities that in this circumstance the normal burden of documentation will be waived and that the presumption of eligibility should be made.

Federal Medicaid officials are also working closely with state Medicaid agencies to coordinate resolution of interstate payment agreements for recipients who are served outside their home states.

The agency will also offer the following relief immediately:

- Health care providers that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricane Katrina, will be paid for services provided and will be exempt from sanctions for noncompliance, unless it is discovered that fraud or abuse occurred.
- Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid.
- Programs will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.

- Medicare contractors may pay the costs of ambulance transfers of patients being evacuated from one health care facility to another.
- Normal prior authorization and out-of-network requirements will also be waived for enrollees of Medicare, Medicaid or SCHIP managed care plans.
- Normal licensing requirements for doctors, nurses and other health care professionals who cross state lines to provide emergency care in stricken areas will be waived as long as the provider is licensed in their home state.
- Certain HIPAA privacy requirements will be waived so that health care providers can talk to family members about a patient's condition even if that patient is unable to grant that permission to the provider.
- Hospitals and other facilities can be flexible in billing for beds that have been dedicated to other uses, for example, if a psychiatric unit bed is used for an acute care patient admitted during the crisis.
- Hospital emergency rooms will not be held liable under the Emergency Medical Treatment and Labor Act (EMTALA) for transferring patients to other facilities for assessment, if the original facility is in the area where a public health emergency has been declared.

More information about CMS emergency relief activities, including a detailed explanation of billing and payment policy revisions, and phone numbers for the state medical assistance offices can be found can be found at www.cms.hhs.gov. Frequently asked questions and their answers on the site will be updated daily by 2pm.

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